Through a glass darkly: understanding depression

Depression is the commonest mental health disorder[1] seen in general practice and, therefore, general practice is well suited to the study of this condition, which has a major impact on the lives of patients and their families. In this issue, we publish three papers that add to our understanding of how depression should be tackled and what might be done to improve patient care.

The intriguing title, *'You're depressed' — 'No I'm not'*, introduces a paper that considers the effect of beliefs and attitudes in the consultation.[2] It explores the clash between the general practitioner's (GP's) beliefs and a medical model of depression with the patient's view of the problem for which they are seeking help and understanding. Previous research[3] has examined either the part played by doctor or patient characteristics. This paper tackles the interaction of these characteristics and the way it may explain much 'under-diagnosis' and the often poor compliance with drug treatment by patients. It also sheds light on the problem of somatization and the 'fat-file' patient. When doctor and patient disagree about the nature of depression, it is not surprising that the patient is reluctant to accept the diagnosis and unlikely to persist with medication. The research also explores the personal experience of depression by both doctors and patients, and the effect of the illness on the individual's model of depression.

How disabling is depression? reports prospective data on 250 patients, all of whom met research diagnostic criteria for major depression and had presented in primary care.[4] The severity of symptoms has always been an important factor when labelling a patient as depressed. There is now increasing emphasis on the subjective reporting of disability in assessing the impact of the disorder and in measuring the effect of treatment. In this study, patients reported higher levels of disability than expected from published norms, and higher levels of disability than found in patients with chronic physical illness. Questionnaires[5] are now available to measure major aspects of life affected by ill-health. The evaluation of disability thus becomes a valuable addition to the measuring of symptoms when assessing the impact of depression on the patient's life.

A major aim of the 'Defeat Depression Campaign', jointly organized by the Royal College of Psychiatrists and the Royal College of General Practitioners, was to influence educational activities for GPs. The paper by Rix and colleagues in this issue[6] reports that two-thirds of GPs in England and Wales were aware of the campaign, and 40% had definitely or possibly made changes in practice as a result of it. The consensus statement on recognition and management of depression in general practice, and the guidelines derived from it, had been read in detail by about one-quarter of responders and was known of by an additional one-third. Despite the difficulties of measuring retrospectively the impact of a national campaign, it is important to consider the influence of co-operation in improving the care of patients. These results are encouraging, but what matters in the long term is how the messages of the campaign are taken up by individual practice teams and how quickly new research, such as reported here, is taken up in day-to-day practice.

General practitioners diagnose and care for most depressed patients without reference to a psychiatrist.[1] Research shows, however, that they fail to recognize illness in many patients who can be diagnosed by structured psychiatric interview.[7] The significance in primary care of undetected depression has recently been questioned. A large naturalistic study in 15 cities worldwide failed to show that non-recognition of depression has serious measurable effects on outcome, perhaps because recognition does not imply optimal treatment.[8] They found that unrecognized cases of depression in primary care have, as a group, less severe illnesses. This does not mean that unrecognized cases would not have benefited from treatment. Nearly half of the unrecognized cases were still suffering mental disorder after a year, leading the authors to conclude that efforts to improve the diagnostic ability of doctors are worthwhile in view of the poor prognosis of depression.

Though much has been learned from epidemiological research, such an overview is not autotomatically applicable in primary care. Neither should conclusions based largely on studies with referred patients be applied unthinkingly to the much larger group of patients who are not referred for specialist care. To advance our understanding, there is the need not only for more research on primary care but in primary care, and for co-operative work between disciplines. GPs and their teams endlessly face the problems of diagnosing and coping with mental health problems when such patients present at the same consulting session as others with a great variety of physical illness. There should be discussion of whether dimensional models of depression used in psychiatric research are immediately relevant to general practice, either from the perspective of GPs or the patients, especially those from different cultural backgrounds. There should be discussion on consultation/liaison approaches; for example, the effect of the community mental health team on the recognition behaviour of GPs.[7] We need to know more about the influence on recognition of depression of the availability of treatment options for the GP. GPs also need clearer guidelines on when it is best to refer and to whom.

Patients and doctors can have differing perceptions of what they consider an appropriate level of care. Taking the consumer's view more seriously is likely to improve the therapeutic alliance between patient and doctor. We also need to come to understand why some health professionals empathize with and befriend sufferers while others are less than sensitive.[9] Above all, we need to acknowledge the extent of our ignorance as well as our knowledge about the nature of depression.

The varied examples of research on depression remind us that it is a complex disorder affecting many aspects of the sufferer's life and that of others. It is more than a simple neuro-chemical mistake with a simple pharmacological solution. It has probably no single cause but rather represents a personal response to a multitude of biological, psychological, social, and cultural factors. The complexity of the problem calls for a variety of approaches. Research over the past few decades has filled gaps in our understanding of this important illness, but we still 'see through a glass darkly'.[10] King[11] points out that research in general practice often reveals much more about appropriate treatments for psychiatric disorders than that conducted in specialist practice, and names the GP as the central player in researching the question of effectiveness. The task is to improve the management of a common and serious illness that is managed largely in primary care. The challenge is being addressed by individual work, multi-disciplinary research, and newly-formed research networks.

ALASTAIR F WRIGHT
Editor, British Journal of General Practice

References
1. Goldberg D, Huxley P. *Common mental disorders: a bio-social model*. London: Tavistock/Routledge, 1992.
2. UMDS MSc in General Practice Teaching Group. 'You're depressed' — 'No I'm not': GPs' and patients' different models of depression. *Br J Gen Pract* 1999; **49:** 123-124.
3. Tylee AT, Freeling P, Kerry S.Why do general practitioners recognize depression in one woman patient yet miss it in another? *Br J Gen Pract* 1993; **43:** 327-330.
4. The Counselling Versus Antidepressants in Primary Care Study Group. How disabling is depression? Evidence from a primary care sample. *Br J Gen Pract* 1999; **49:** 95-98.
5. Ware JE, Sherbourne CD. The MOD 36-item short form health survey (SF-36): 1. Conceptual framework and item selection. *Med Care* 1992; **30:** 473-483.
6. Rix S, Paykel E S, Lelliott P, *et al*. Impact of a national campaign on GP education: an evaluation of the Defeat Depression Campaign. *Br J Gen Pract* 1999; **49:** 99-102.
7. Ormel J, Koeter M, van de Brink W, van de Willige G. The extent of non-recognition of mental health problems in primary care: effects on management and outcomes. In: Goldberg D, Tantam D (eds). *The Public Health Impact of Mental Disorder*. Bern: Hogrefe and Huber, 1990.
8. Goldberg D, Privett M, Ustun B, *et al*. The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study in 15 cities. *Br J Gen Pract*, 1998; **48:** 1840-1844.
9. Crisp AH. The stigmatization of sufferers with mental disorders. *Br J Gen Pract* 1999; **49:** 3-4.
10. *Holy Bible* (King James version). 1 Corinthians: chapter 13, verse 12.
11. King M. Mental health research in general practice: from headcounts to outcomes. *Br J Gen Pract* 1998; **48:**1295-1296.

Address for correspondence
Dr A F Wright, FRCPsych (Hon), 5 Alburne Crescent, Glenrothes, Fife KY7 5RL.

Runner's knee: what is it and what helps?

'RUNNER'S knee' is a term that is used to describe vague knee pain that commonly occurs in physically active people. The technical term for runner's knee is patellofemoral pain syndrome, and it is characterized by an insidious onset of diffuse knee pain made worse by ascending or descending grades, squatting, kneeling, sitting with the knee in flexion, and on rising after long periods of sitting. It is relieved by rest and cannot be localized to a specific anatomic structure. A study in a Finnish sports clinic reported that 33% of its cases were of patellofemoral pain syndrome, making it the most common presenting condition.[1] Another study involving new recruits in the Israeli army reported that 15% of the soldiers developed the syndrome during their first 14 weeks of basic training.[2] While sustained physical activity is a cause of the syndrome, there are individual factors that predispose individuals.

The prognosis is variable, with many initial cases improving while other new cases develop over time.[3] After six years, 35% of the patients from the originally symptomatic group in this prospective study had persisting knee pain, although only 8% had persisting pain that hindered physical activity. Forty-nine consecutive patients with unilateral patellofemoral pain syndrome were followed-up for three years and the factors associated with improvements in pain were analysed.[4] Seventy per cent of participants made a complete recovery, and only younger age predicted a good outcome. The authors concluded that there was no ' ... general or biomechanical factor that could reliably predict the outcome ... in the non-operative management of patellofemoral pain syndrome'. An eight-year observational study of adolescent girls with anterior knee pain found that only 13% of the participants had worse symptoms at follow-up.[5] This led the authors to conclude that the condition tended to improve with time, that serious disability was rare, and that surgical treatment seldom need be considered.

There are many invasive and non-invasive therapies recommended for patellofemoral pain syndrome, yet few of these are based on convincing clinical trial evidence. The treatments range from intramuscular and intra-articular injections, to knee braces, orthotics, knee-taping, and non-steroidal anti-inflammatory medication. There are also surgical treatments available, such as patellar debridement, lateral retinacular release, and proximal extensor mechanism realignment.[6] A review of the non-operative therapies for patellofemoral pain syndrome found only five randomized controlled trials, which seems a very small number for such a common condition.[7] The quality of these clinical trials is variable, and there is wider concern about the poor methodological quality of the literature on physical therapy for musculoskeletal conditions in general.[8] While there are challenges in designing randomized controlled trials to evaluate physical therapies, there are ways of undertaking such studies.[9]

One of the difficulties in searching for articles on therapy for patellofemoral pain syndrome is the evolution in terminology over the past 20 years. This, in part, reflects the distinctions now possible with the advent of arthroscopy, although there has been no clear chronological point of change. The original term was chondromalacia patellae; then patella chondropathy, patellofemoral arthralgia, patellalgia, runner's knee, anterior knee pain, and retropatellar pain syndrome. Chondromalacia patellae is still a clinical condition with signs of patellar cartilage damage, while patellofemoral pain syndrome has similar symptoms but no sign of cartilage damage. Although the clinical symptoms are similar for both chondromalacia patellae and patellofemoral pain syndrome, it is not known if there is any relationship between the two conditions. One of the difficulties with applying the results of clinical trials is the inclusion of patients with and without patellar cartilage damage.

One study in adolescent females (patellar cartilage status not reported) found that orthotic devices were more effective in controlling pain than a control flat insole. While this is an important finding, it is not clear if the control patients were aware that they were not in the intervention group.[10] Failure to mask or blind the control group to orthotic intervention could produce a negative attitude in the control group, and hence give a false-positive finding in the intervention group, invalidating the results.

Knee braces are a popular treatment for knee disorders. A well-designed clinical trial with Israeli army recruits found that simple knee sleeves and a specially designed patellar sleeve (Genutrain) produced significantly worse outcomes than the conservative therapy control group (i.e. maintaining activity and avoiding pain-causing activity, and/or no therapy or simple muscle stretching and strengthening).[2] Both sleeves caused problems with skin abrasions, and 80% of the conservative treatment group were better at the end of the study. The lower rates of recovery in the elastic sleeve and Genutrain group, and the side-effects of skin abrasions, suggest that this is not a good form of initial treatment.

A technique that has become known as 'McConnell taping' uses adhesive tape to control lateral patellar rotation and tilt, and was introduced to control patellar maltracking, relieve pain, and assist with quadriceps rehabilitation.[11] It is designed to accompany strengthening and stretching activities, and its initial

success rate in an uncontrolled study was 96%.[11] A randomized controlled trial of 25 patients reported that the McConnell technique improved some parameters, such as pain, radiographic findings, and EMG activity, but concluded that 'there is no beneficial effect of adding a patellar taping programme to a standard physical therapy programme'; i.e. the control group experienced the same benefits.[12] The small size of this study may not have had the power to detect a small benefit from the taping.

Patellofemoral pain syndrome may be the most common musculoskeletal condition in healthy active adults and can be easily diagnosed by general practitioners on the basis of history and simple examination. It is surprising that there are so few randomized trials of therapy for a condition where so many treatments are recommended. Many studies assume that alteration of abnormal biomechanics will result in clinical benefit. These assumptions need to be assessed using clinical outcomes in larger, better designed clinical trials. Such an approach would raise the standard of evidence for the treatment of musculoskeletal conditions. Conservative therapy, such as quadriceps strengthening and stretching exercises, seems to be as effective as any specific therapy, and for uncomplicated cases there is no justification for long periods of expensive therapy.

BRUCE ARROLL
Associate Professor, Department of General Practice, University of Auckland

A EDWARDS
Senior Lecturer in General Practice and Sports Medicine Physician, Department of General Practice, University of Auckland

References

1. Kannus P, Aho H, Jarvinen M, Niittymaki S. Computerised recording of visits to an outpatient sports clinic. *Am J Sports Med* 1987; **987:** 79-85.
2. Finestone A, Radin EL, Lev B, *et al*. Treatment of overuse patellofemoral pain. *Clin Orthop* 1993; **293:** 208-210.
3. Milgrom C, Finestone A, Shlamkovitch N, Giladi M. Long term follow up of recruits with patellofemoral pain caused by overactivity. A prospective study. *Clin Orthop* 1996; **331:** 256-260.
4. Kannus P, Niittymaki S. Which factors predict outcome in the non-operative treatment of patellofemoral pain syndrome? A prospective follow-up study. *Med Sci Sports Exerc* 1994; **26:** 289-296.
5. Sandow MJ, Goodfellow JW. The natural history of anterior knee pain in adolescents. *J Bone Joint Surg* 1985; **67-B:** 36-38.
6. Shelton GL, Thigpen LK. Rehabilitation of patellofemoral dysfunction: a review of the literature. *J Ortho Phys Ther* 1991; **14:** 243-249.
7. Arroll B, Ellis-Pegler E, Edwards A, Sutcliffe G. Patellofemoral pain syndrome. A critical review of the clinical trials on non-operative therapy. *Am J Sports Med* 1997; **25:** 207-212.
8. Beckerman H, Bouter LM, van der Keidjen GJ, *et al*. Efficacy of physiotherapy for musculoskeletal disorders: what can we learn from research? *Br J Gen Pract* 1993; **43:** 73-77.
9. Rudicel S, Esdaile J. The randomized clinical trial in orthopaedics: obligation or option? *J Bone Joint Surg* 1985; **12:** 84-93.
10. Eng JE, Pierrynowski MR. Evaluation of soft foot orthotics in the treatment of patellofemoral pain syndrome. *Phys Ther* 1993; **73:** 62-70.
11. McConnell J. The management of chondromalacia patellae: a long term solution. *Aust J Physiotherapy* 1986; **32:** 215-223.
12. Kowall MG, Kilk G, Nuber GW, *et al*. Patellar taping in the treatment of patellofemoral pain. A prospective randomized study. *Am J Sports Med* 1996; **24:** 61-66.

Address for correspondence

Professor Bruce Arroll, Department of General Practice, University of Auckland, Private Bag 92019, Auckland 1, New Zealand. E-mail: b.arroll@auckland.ac.nz